STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 06/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILTON & HATTIE KUTZ HOME	704 RIVER ROAD WILMINGTON, DE 19809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from June 19, 2018 to June 25, 2018. The facility census the first day of the survey was 87. During this period, an Emergency Preparedness survey was also conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey, no deficiencies were cited.	E 000		
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from June 19, 2018 to June 25, 2018. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 87. The survey sample size was 23. Abbreviations / definitions used in this 2567 are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; CNA - Certified Nurses's Aide; Anxiety - general term for several disorders that cause nervousness, fear, apprehension and worrying; Dementia - loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; MDS - Minimum Data Set/standardized assessment forms used in nursing homes;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/09/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Neurological checks- series of simple tests to determine if the nervous system was impaired.	F 000		
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.	F 583		8/10/18

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F 583	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure adequate privacy for eight 503, 504, 506, 507, 603, 604, 605, 606 out of 58 resident rooms surveyed. Findings include: 6/21/18 at 11:50 AM Observation - In room 506 it was discovered the exit door opened inside of the privacy curtain of the bed by the door. Therefore the resident occupying the bed in this area would not have privacy during personal care. 6/21/18 - After further investigation it was revealed that Rooms 503, 504, 506, 507, 603, 604, 605, and 606 all had doors that opened inside of the privacy curtain. 6/21/18 around 1:00 PM - E2 (DON) and E3 (ADON) were informed of the privacy issue in rooms 503, 504, 506, 507, 603, 604, 605, and 606 that all the doors to the identified rooms open inside the privacy curtain. 6/21/18 around 1:15 PM - After demonstrating how the exit door opened within the privacy curtain. E2 DON agreed that the situation did not provide adequate privacy. 6/22/18 at 3:50 PM - E1 (NHA) was informed of rooms 503, 504, 506, 507, 603, 604, 605, and 606 all having doors that open into the privacy curtain and possibly exposing the resident in the bed by the door. This finding was reviewed with E1, E2, and E3 at the exit conference on 6/26/18 at 1:30 PM.	F 583	A. Cubicle curtains and tracks for all rooms identified will be replaced with those providing privacy. B. Cubicle curtains in all resident rooms have been checked to insure resident privacy C. 1. A check for all cubicle curtains will be added to the monthly Preventative Maintenance schedule (See attached M-1) 2. Maintenance Director will in- service all House keeping and Maintenance staff to routinely check cubicle curtains for damage and for proper installation D. The Maintenance Director will review the completed Preventative Maintenance records monthly for 4 months for 100% compliance, then quarterly for 4 quarters for 100% compliance; results will be reported at the monthly QAPI meeting	

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F 689	Continued From page 3	F 689		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, interview and other facility documentation it was determined that the facility failed to ensure adequate supervision to prevent a fall for one (R15) out of 23 sampled residents. Findings include: Review of R15's clinical record revealed: 11/11/13 - Admission 9/26/17 - Care plan for self-care deficit related to dementia and anxiety interventions included: -Total assist of one required for personal hygiene. - Extensive assistance of one person required for bed mobility, and toileting. - Supervision assistance of one with gait belt needed for all transfers. Care plan for potential for injury related to a history of falls including interventions: - Supervision assistance of one with gait belt needed for all transfers. - Assess environment for safety remove any barriers.	F 689	A Past practices can not be corrected for resident R15 care plans reviewed for accuracy and noted to reflect level of care required. B Will review all residents MDS assessments and Care Plans to insure accurate supervision for toileting and transfer is noted. C 1. Revised the Risk Management Log fall section (See attached N-1) to monitor that the affected residents received the required level of supervision during toileting. 2. The charge nurse will report residents transfer status and level of supervision to the caregivers at the beginning of each shift as well as during the shift with any changes. 3. The Staff Educator or designee will re in-service nursing staff on the transfer policy (See attached N-2)and the	7/23/18

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F 689	Continued From page 4 - Ensure adequate lighting and clutter free path. 12/6/17 - Fall risk assessment indicated R15 was a high risk for falling. 12/7/17 - Quarterly MDS Assessment documented R15 needed extensive assistance with one person physical assistance for toileting. When moving from seated to standing position, walking, moving off and on the toilet, and surface to surface transfer between bed, chair, or wheelchair R15 was not steady and only able to stabilize with staff assistance. 1/23/18 at 7:45 AM - Facility fall investigation revealed R15 suffered a fall while being toileted resulting with a red area to the left side of head. Neurological checks were within normal limits. Pain was denied and R15 could move all extremities on examination. E5 (CNA) was toileting R15 and left the resident unattended to retrieve supplies. 6/22/18 12:00 PM - During a discussion with E2 (DON) and E3 (ADON) about R15's fall it was revealed that it was not a practice to leave R15 alone while being toileted and confirmed that R15's fall was due to a lack of supervision. 6/22/18 at 3:50 PM - Discussed with E1 (NHA) findings for R15's fall was due to the lack of supervision. This finding was reviewed with E1, E2, and E3 at the exit conference on 6/26/18 at 1:30 PM.	F 689	requirement to follow residents plans of care. D. 1. The Director of Nursing(DON) or designee will monitor, track and audit all falls for compliance with appropriate level of supervision during toileting, weekly X4 weeks until 100% compliance is achieved, then monthly X4 months until 100% compliance is achieved, then quarterly X4 quarters until 100% compliance is achieved. 2. The DON or designee will report results biweekly at the risk management meetings and at the monthly Quality Assurance Performance Improvement meetings for review, discussion and evaluation.	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: The Milton & Hattie Kutz Home **DATE SURVEY COMPLETED: June 25, 2018**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from June 19, 2018 to June 25, 2018. The facility census the first day of the survey was 87. During this period, an Emergency Preparedness survey was also conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey, no deficiencies were cited.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is met as evidenced by the following:** Cross Refer to the CMS 2567-L survey completed June 25, 2018: F583, and F689	Cross refer to F 583 Cross refer to F 689	8/10/18 7/23/18

Provider's Signature _____ Title Executive Director Date 7/18/18

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Provider's Signature _____ Title _____ Date _____